# ***CLAIMS CLUES***

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## ***AHCCCS NPI CONTINGENCY PLANNING***

All AHCCCS system programming changes to support NPI implementation, with the exception of those related to the 835 transaction were completed and promoted in October 2006. Since that time AHCCCS has been operating in an optional use period allowing providers to submit their Legacy ID numbers ***OR*** NPI numbers known to the AHCCCS system.

Weekly reports are run to track and document the number of NPIs on the AHCCCS system vs. the total number of NPIs identified as needed. To date these reports demonstrate the lack of NPI "sharing" by AHCCCS providers.

A list of currently identified challenges and/or areas of concern including many NPIs to one AHCCCS ID; one NPI to multiple AHCCCS Ids; billing providers, who are also service providers; ongoing support and recognition of "secondary" NPI information not "accessible" to Billing Providers; review of AHCCCS Validator editing for NPI information; etc. is being maintained and actively addressed.

NPI information, as captured in PMMIS, is shared with all Managed Care Organizations on a weekly basis for comparison to their internal provider systems.

Please direct any questions to the AHCCCS HIPAA Workgroup
ahcccshipaaworkgroup@azahcccs.gov

## ***AHCCCS NPI CONTINGENCY PLANNING*** cont.

**837 Claims and Encounter Transactions**

Primary (rendering/service) providers SHOULD use an NPI (if required for their provider type), but AHCCCS will accept submission of both the NPI and/or other legacy identifiers until **1/1/2008.**

Secondary providers (referring, attending, operating) (if required or submitted) SHOULD use an NPI, but AHCCCS will accept submissions of both the NPI and/or other legacy identifiers until **3/1/2008.**

**NCPDP Claims and Encounter Transactions**

Primary (rendering/service) providers SHOULD use an NPI, but AHCCCS will accept submissions of both the NPI and/or other legacy identifiers until **1/1/2008.**

Secondary providers (prescribing providers) SHOULD use an NPI, but AHCCCS will accept submissions of both the NPI and/or other legacy identifiers until **3/1/2008.**

**270/271 Transactions**

Providers SHOULD use an NPI (if required for their provider type), but AHCCCS will accept submissions of both the NPI and/or other legacy identifiers until **1/1/2008.**

**On-line Web Based Transactions, claim status look up**

Providers SHOULD use an NPI (if required for their provider type), but AHCCCS will accept both the NPI and/or other legacy identifiers until **1/1/2008.**

**Prior Authorization**

Providers SHOULD use an NPI (if required for their provider type), but AHCCCS will accept both the NPI and/or other legacy identifiers until **1/1/2008.**

**Provider Registration Records**

Provider records SHOULD contain valid NPI information (if required for the provider type), but AHCCCS will not suspend any Provider records for lack of an NPI until **5/23/2008.**

**Paper Claim Submission**

AHCCCS will continue to accept both old and revised version of CMS 1500 and UB-92 and revised UB-04 until **10/1/2007.** Effective **10/1/2007**, AHCCCS will accept ONLY revised version of CMS 1500 claim form and UB-04 claim form.

Please note that Chapter additions have been posted to the Fee for Service Provider Manual with information regarding these revised forms. See Chapter 5.5 for information regarding billing on the revised CMS 1500 and refer to Chapter 6.5 for information regarding billing on the UB-04 claim form.

## RATE ESTABLISHED FOR COMPANION CARE – S5135

The Arizona Health Care Cost Containment System Administration has established a rate for HCPCS Level II code S5135 – Companion Care, adult (e.g. IADL/ADL); per 15 minutes. Effective for dates of service on or after May 1, 2007 the Fee-for-Service rate for HCPCS code S5135 will be $4.06 per fifteen-minute unit. The daily maximum units that can be billed for this code will be set at 23, or 5¾ hours. HCPCS code S5136 – Companion Care, adult (e.g. IADL/ADL); per diem – will continue to be paid "By Report."

As described in Chapter 1200 of the AHCCCS Medical policy manual, these codes should be utilized to bill when staff accompanies members who are not able to be safely transported alone to medical appointments. Both codes S5135 and S5136 require pre-authorization and will be open for Provider Types 22, 24, 36, 39, 40, 49, 50 and 57.

If you have questions regarding these codes and rates, contact Todd Schwarz by phone at (602) 417-4487 or by email at *Todd.Schwarz@azahcccs.gov.*

## CLARIFICATION OF AHCCCS IHS/638 TELEHEALTH POLICY

Just a reminder that ONLY AHCCCS registered IHS/638 providers may bill AHCCCS and be reimbursed for providing Telehealth services (or any other medical service).

## AHCCCS PROVIDER PARTICIPATION TO BE TERMINATED FOR INACTIVITY

An AHCCCS provider's participation in the AHCCCS program may be terminated for any of several reasons, including inactivity. Provider participation may be terminated if the provider does not submit a claim to the AHCCCS Administration or one of the AHCCCS-contracted health plans or program contractors within the past 24 months. If AHCCCS has not received a claim or an encounter for the past 24 months, these providers will be terminated effective June 2007.

A new registration packet will be required to reactivate providers who reapply following termination for inactivity.

Providers should refer to Chapter 3 of the AHCCCS Fee-for-Service Provider Manual for information on provider participation.

# AHCCCS TO PARTICIPATE IN A MANDATORY CMS AUDIT

In 2002, the Federal Government passed the Improper Payments Information Act (IPA) requiring Federal Agencies to annually review their programs which are susceptible to significant improper payments. The Office of Management and Budget (OMB) identified Medicaid and SCHIP as such programs and has required the Centers for Medicare and Medicaid (CMS) to report annually a national payment error rate for both programs. The new audit process is called PERM (Payment Error Rate Measurement). The State of Arizona will be required to participate beginning with Federal Fiscal Year (FFY) 2008 and every three years thereafter.

CMS has hired contractors to complete the payment reviews. They are estimating 100 payments reviews per year for each program (Medicaid and SCHIP), and will require medical documentation to verify that a payment was medically appropriate and covered in order for the payment to be considered correct. The contractor (Livanta) will be requesting this documentation from the AHCCCS providers. If requested documentation is not provided, the State will be cited with an erroneous payment error. Since CMS has hired the contractors, all HIPAA requirements have been met and as an AHCCCS registered provider, you will be required to provide the necessary requested documentation to them.

The payment samples will be selected from all payments made in a quarter beginning October through December 2007. The first sample should be assigned by February 2008. The provider will have ninety (90) days to provide the requested documentation. The Arizona State PERM contact, Kim Wilson or Albert Escobedo, will be following up on the samples and contacting providers who have not responded to documentation requests.

This is a mandatory process and we would like to make it an effective process for all involved. We plan to notify the providers of selected payments when we receive our samples.

If you have any questions regarding this process, feel free to call Kim Wilson at (602)417-4563 or Albert Escobedo at (602)417-4562.

# NEW CODE FOR HOME HEALTH NURSING VISITS

The Arizona Health Care Cost Containment System Administration has approved use of code G0154 to report home health nursing visits. Since October 1, 2003 home health nursing visits have been reported using codes S9123 – Nursing care, in the home; by a registered nurse, per hour – and S9124 – Nursing care, in the home; by a registered nurse, per hour. Home health nursing visits are often less than one-hour in duration.

Effective with dates of service on or after October 1, 2007 home health nursing visits of 2 hours or less in duration or multiple visits that do not exceed a total of four hours in one day are to be reported with HCPCS code G0154 when either a Registered Nurse or a Licensed Practical Nurse is sent. When a visit exceeds two hours in duration, or multiple visits exceed four hours in a single day, services should be billed using HCPCS code S9123 when services are provided by a RN and S9124 when services are provided by a LPN per the following table:

**AHCCCS - Coding for Home Health Nursing**

| Provider Type | | Intermittent - Brief Visit (Billed in 15 minute Units for visits of 2 hours or less in duration, up to a total of four hours per day) | | Continuous - Hourly (Billed in Hourly Units for visits of more than two hours in duration or services exceeding four hours in a single day) | |
|---|---|---|---|---|---|
| | | RN | LPN | RN | LPN |
| | | HCPCS Code | HCPCS Code | HCPCS Code | HCPCS Code |
| Medicare Certified Home Health Agency | 2, 23 | G0154 | G0154 | S9123 | S9124 |
| State Certified Home Health Agency | 39, 81, 95 | G0154 | Not Covered | S9123 | S9124 |
| Independent Nurse | 46 | G0154 | Not Covered | S9123 | S9124 |

The rates for code G0154 will be published by September 1, 2007 with the rates for other Home and Community Based Services that will be effective October 1, 2007. I you have any questions contact Todd Schwarz at (602)417-4487 or via e-mail at Todd.Schwarz@azahcccs.gov.